EPC

Elite Performance Clinic

CLIENT INFORMATION FORM

Last Name _____ First Name _____

Address _____ City/State/Zip _____

Phone Number _____ Date of Birth ____/____/____

Email Address _____

How did you learn about us?

☐ Yelp ☐ Google ☐ Instagram ☐ Friend ☐ Other (please specify) _____

Emergency Contact Information

Last Name _____ First Name _____

Phone Number _____ Relationship _____

Responsible Party (if different from patient)

Last Name _____ First Name _____

Phone Number _____ Relationship _____

Insurance Information

Insurance Provider: _____ Policy Number: _____

Group Number: _____ Primary Subscriber: _____

Subscriber's DOB: _____ Relationship to Patient: _____

Symptoms

Reason for Visit: _____ When did you notice the symptoms? _____

Is this condition getting progressively worse?

Yes / No

Where is the problem located? _____

What activities are difficult to perform? (Check all that apply)

☐ Walking ☐ Standing ☐ Sitting

☐ Lifting ☐ Bending ☐ Reaching

☐ Other (please specify)

_____

Type of Pain (Check all that apply)

- ☐ Sharp
- ☐ Dull
- ☐ Throbbing
- ☐ Burning
- ☐ Aching
- ☐ Shooting
- ☐ Stabbing
- ☐ Tingling
- ☐ Numbness

Severity of Pain Scale (1-10): _____

Treatment Received Already: _____

Name of Doctor Who Treated You: _____

Doctor Phone Number: _____

Health History (Check all that apply)

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Epilepsy or Seizures
- ☐ Any Other Medical Condition (please specify) _____
- ☐ Diabetes
- ☐ Thyroid Disorders
- ☐ Pregnancy
- ☐ Claustrophobia
- ☐ Sensitivity to Heat or Cold
- ☐ Recent Surgery or Injury
- ☐ Chronic Skin Conditions (e.g., eczema, psoriasis)

Medical History

Have you had any previous surgeries? Yes / No
If yes please explain in detail:

_____

_____

Please list all medications you are currently taking (including OTC medications):

_____

_____

Have you had any previous injuries? Yes / No
If yes please explain in detail:

_____

_____

_____

Please list all supplements and/ or herbals you are currently taking:

_____

_____

_____

Daily Habits

Do you smoke? Yes / No
If yes, how often?

_____

Do you consume alcohol? Yes / No
If yes, how often?

_____

Do you engage in regular physical activity? Yes / No
If yes, please specify:
Frequency: _____
Type of Activity: _____

By signing below, I acknowledge that I have read and agree to the terms and conditions outlined in Elite Performance Clinic's policies and all information I have provided is accurate.

Signature: _____ Date: _____

EPC
Elite Performance Clinic

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

 Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

 The practice reserves the right to change the privacy policy as allowed by law.

 The practice has the right to restrict the use of the information but the practice does not have to agree to those

restrictions.

 The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

 The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **Y/N**
May we leave a message on your answering machine at home or on your cell phone? **Y/N**
May we discuss your medical condition with any member of your family? **Y/N**
If YES, please name the members allowed:

_____

_____

_____

Print Name: _____ Date: _____

Signature: _____

Witness Name (if applicable): _____ Date: _____

Elite Performance Clinic

Patient Financial Policy

At Elite Performance Clinic, we participate with most commercial U.S. insurance plans. Please confirm your **out-of-network** and **in-network** benefits directly with your insurance company. Key details to review include: **Annual deductible, Co-payment or co-insurance amounts for office visits, Authorization requirements.** If a charge is not covered by your plan and we are unaware, you will receive a **balance bill** after a denial is issued by your insurance carrier.

As a courtesy, we will verify your insurance benefits; however, the information provided may be incorrect. It is ultimately the **patient's responsibility** to understand their plan, including authorization requirements, plan exclusions. If benefits are misquoted to us, you will be billed for the correct amount.

Many insurance plans have a cap on the number of physical therapy visits allowed. It is the **patient's responsibility** to track their visit count and ensure the limit is not exceeded. If the limit is exceeded, you will be billed directly for additional visits.

Should your account be sent to our collections department, a **$15 fee** will be applied.

Our cancellation policy requires patients to arrive at least 10 minutes prior to their scheduled appointment to allow time for preparation. If a cancellation is necessary, we request at least one business day's notice to avoid incurring a $75 fee.

We participate in and accept assignments under the Medicare program. Please note: Medicare will **not cover physical therapy** if you are receiving **any home health care services**, even if unrelated to the reason for physical therapy. Examples include: Nurse, aide, or therapist visits for blood pressure checks, injections, medications, etc. If Medicare denies coverage for this reason, you will be responsible for the cost of the visit.

Assignment of Benefits and Financial Responsibility

I, _____, hereby assign all professional or medical expense benefits allowable and payable to me under my current insurance policy to Elite Performance Clinic as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.**

This payment will not exceed my total indebtedness to the assignee. I agree to pay, in a timely manner, any remaining balance of charges for professional services that are not covered by my insurance policy. A photocopy of this Assignment shall be considered as valid and effective as the original.

If my treatment is related to a personal injury involving third-party insurance or legal representation, I agree to sign a lien against any settlement received by me and/or my attorney. In the event that legal action becomes necessary to collect an unpaid balance for services rendered, I agree to pay reasonable attorney's fees and any other costs deemed appropriate by the Court.

I hereby authorize treatment for the person named above and agree to pay all fees and charges for such treatment. If I have insurance coverage, I authorize my insurance company to process and pay all claims for services rendered to Elite Performance Clinic. I understand that if, for any reason, my insurance company does not pay Elite Performance Clinic for authorized services, I will be financially responsible for the balance. I agree to pay Elite Performance Clinic directly and seek reimbursement from my insurance company to resolve the debt.

Your signature below indicates that you understand and agree to this financial policy, including your responsibilities for any charges incurred at our office.

Participant's Name: _____

Participant's Signature: _____ Date: _____

If the participant is under 18 years of age, a parent or legal guardian must also sign below:

Parent/Legal Guardian Name (if applicable): _____

Parent/Legal Guardian Signature: _____ Date: _____

Elite Performance Clinic

Notice of Information Practices Consent Form

I, _____, hereby acknowledge that I have been informed of and understand the nature of the services offered by Elite Performance Clinic, including but not limited to red light therapy, chiropractic care, personal training, cold plunge, sauna, PEMF Therapy, massage therapy, private pilates classes, ozone treatment, and cupping. I understand that these services involve various treatments and therapies designed to improve physical health, well-being, and performance.

I understand that the services provided by Elite Performance Clinic may involve physical exertion, therapeutic interventions, and exposure to various environmental conditions. I acknowledge that the results and benefits of these services may vary depending on individual factors such as health status, fitness level, and adherence to treatment plans. I have been provided with information regarding the potential risks, benefits, and alternatives associated with each service offered by Elite Performance Clinic. I understand that while these services may offer potential benefits, there are also inherent risks and limitations involved. I acknowledge that no guarantees or assurances have been made regarding the outcomes of these services.

I understand that it is my responsibility to disclose any pre-existing medical conditions, injuries, or other health concerns that may affect my ability to safely participate in the services offered by Elite Performance Clinic. I agree to inform the staff of Elite Performance Clinic of any changes to my health status or medical history that may occur during the course of my participation in these services. I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations by notifying the clinic. I also understand that Elite Performance Clinic will consider such requests on a case-by-case basis but is not obligated to agree to restrictions.

I understand that I have the right to ask questions and seek clarification about any aspect of the services offered by Elite Performance Clinic. I acknowledge that I have been encouraged to communicate openly with the staff regarding any concerns or preferences I may have regarding my treatment plan. Elite Performance Clinic and its staff are not responsible for any loss, damage, or injury that may occur as a result of my participation in its services, except in cases of their gross negligence or willful misconduct.

I acknowledge and agree that Elite Performance Clinic may, from time to time, photograph or record video/audio footage of clients participating in its services for promotional and marketing purposes. I consent to the use of such photographs or recordings, which may include my likeness, voice, and/or image, for promotional use by Elite Performance Clinic. I agree not to engage in any form of video recording or photography of other clients within the premises of Elite Performance Clinic without prior explicit consent from the management or authorized personnel. I understand that unauthorized video recording or photography may infringe upon the privacy rights of other participants and staff members. I acknowledge that any violation of this agreement may result in disciplinary action, including but not limited to expulsion from the premises and legal consequences. I understand that my participation in the services offered by Elite Performance Clinic is voluntary, and I hereby release, waive, and discharge Elite Performance Clinic, its owners, employees, contractors, and agents from any and all claims, damages, or liabilities arising out of or related to the use of such photographs or recordings for promotional purposes.

I have read and fully understand **Elite Performance Clinic's Notice of Information Practices**. I understand that Elite Performance Clinic may use or disclose my personal health information for the purposes of: carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment.

I hereby consent to participate in the services offered by Elite Performance Clinic, understanding the risks, benefits, and limitations associated with these services.

Participant's Name: _____

Participant's Signature: _____ Date: _____

If the participant is under 18 years of age, a parent or legal guardian must also sign below:

Parent/Legal Guardian Name (if applicable): _____

Parent/Legal Guardian Signature: _____ Date: _____

EPC

Elite Performance Clinic

Assumption of Risk and Liability Form

I, _____, understand and acknowledge that there are inherent risks associated with participating in the services offered by Elite Performance Clinic, including but not limited to, chiropractic care, physical therapy, personal training, red light therapy, cold plunge, sauna, PEMF Therapy, massage therapy, private pilates classes, ozone treatment, and cupping. I understand that these services involve physical exertion and may require me to perform activities that could result in injury, illness, or other adverse health effects.

In consideration of being allowed to participate in the services offered by Elite Performance Clinic, I voluntarily assume all risks associated with such participation, including but not limited to:

- Risk of injury resulting from physical activity, including strains, sprains, fractures, and other musculoskeletal injuries.
- Risk of illness resulting from exposure to temperature extremes, including heat exhaustion, dehydration, or hypothermia.
- Risk of adverse reactions to treatments or therapies, including allergic reactions or other adverse health effects.
- Risk of exacerbation of pre-existing health conditions or injuries.
- Risk of discomfort or pain resulting from the performance of certain activities or treatments.
- Risk of emotional or psychological discomfort resulting from participation in certain activities or treatments.

I understand that Elite Performance Clinic and its staff will take reasonable precautions to minimize these risks, including providing appropriate instruction, supervision, and equipment. However, I acknowledge that it is not possible to eliminate all risks associated with these activities.

I hereby release, waive, discharge, and covenant not to sue Elite Performance Clinic, its owners, employees, contractors, and agents from any and all liability, claims, demands, actions, or causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by me or to any property belonging to me while participating in the services offered by Elite Performance Clinic, whether caused by the negligence of Elite Performance Clinic or otherwise.

I further agree to indemnify and hold harmless Elite Performance Clinic, its owners, employees, contractors, and agents from any and all liability, claims, demands, actions, or causes of action whatsoever arising out of or related to my participation in the services offered by Elite Performance Clinic.

I have read this Assumption of Risk and Liability Form carefully and understand its contents. I am aware that by signing this form, I am giving up substantial legal rights, including the right to sue Elite Performance Clinic for any injuries or damages sustained as a result of my participation in its services.

Participant's Name: _____

Participant's Signature: _____ Date: _____

If the participant is under 18 years of age, a parent or legal guardian must also sign below:

Parent/Legal Guardian Name (if applicable): _____

Parent/Legal Guardian Signature: _____ Date: _____

EPC

Elite Performance Clinic

Cancellation Policy

At Elite Performance Clinic, each missed appointment without proper notice prevents another patient from receiving care. To ensure fairness, we reserve the right to charge a **$75 cancellation** fee for missed appointments (“no-shows”) or appointments not canceled with at least 24 hours notice.

This fee is **not** covered by insurance and remains the patient’s responsibility, payable before your next appointment. Repeated no-shows within a 12-month period may result in termination from our practice.

This policy allows us to manage our schedules effectively and accommodate other clients who may be waiting for an appointment. We appreciate your understanding and cooperation as we strive to provide the best care for all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Participant's Name: _____

Participant's Signature: _____ Date: _____